

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-023350

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 759 STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1 5117

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF

J.B. McRae, D.O. MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Duchman</u>		2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. JOSEPH</u>		Length of stay in 1b <u>1 week</u>	c. CITY OR TOWN <u>MOUND CITY</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MO. METH. HOSP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3 miles EAST</u>
3. NAME OF DECEASED (Type or print) First <u>LELAND</u> Middle <u>OFFICER</u> Last <u>OFFICER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>17</u> Year <u>1963</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-21-1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (City and state or country) <u>Guilford Mo.</u>
13a. FATHER'S NAME <u>THOMAS OFFICER</u>		13b. MOTHER'S MAIDEN NAME <u>MARGARET STOTTS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>302 MRS. LELAND OFFICER - MOUND CITY MO.</u>	
18. CAUSE OF DEATH (Enter only one cause plus time for each) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rapid Ventricular Fibrillation</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pulmonary edema</u>		<u>1 week</u>	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Preparing patient for resection of sigmoid {given}</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>9:00</u> a.m. <u>9:00</u> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>Jan 2 / 63</u> to <u>June 17 / 63</u> and last saw him alive on <u>June 17 / 63</u> Death occurred at <u>9:00</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. Bruce McRae D.O.</u>		22b. ADDRESS <u>Mound City, Mo.</u>	
22c. DATE SIGNED <u>6/18/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-19-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE</u>	
23d. LOCATION (City, town, or county) (State) <u>Mound City - Mo.</u>		23e. DATE RECD. BY LOCAL REG. <u>June 19, 1963</u>	
23f. FUNERAL DIRECTOR <u>JAMES H. CRAWFORD - MOUND CITY MO</u>		23g. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

JUN 28 1963

JUL 3 1963

Permit issued 6-14-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James H. Crawford

Licensed Embalmer No. 4796

P. O. Address Mountain City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.